

## Interprofessional Education and Collaborative Practice—If Not Now, When?

The woman lying on the stretcher seemed irritated at our questions about how she had received the bruises on her face and chest. She smelled of alcohol, dirt, and sweat, and her disheveled clothes suggested that she lived on the street. The nurses seemed to know her.

“This is Marie Timmins. She’s been here before,” said Melissa, her nurse. (All identifiers have been changed.) “Alcohol, drugs. Minor trauma. That’s about it. Same old, same old.”

The triage note described an assault and possible intimate partner violence. Orlando, the resident working with me, had gotten some history from the patient, who mostly wanted to sleep and was asking for a sandwich. Orlando had brought me to see her and was recommending that we do a CT scan of the head and ask the social worker to talk with her to help her and also to help us understand her situation. I introduced myself to the patient: “Hello, Ms. Timmins. I am Dr. Sklar, the attending physician, and I’m here with your doctor. He tells me that you were beaten up. Was it your boyfriend? We need to know what happened and would like to order some tests. Is that okay?”

“I’m okay. I just need something to eat,” she said. “I don’t need any tests.”

“But your face is all swollen and bruised. It looks like you’ve been beaten. Something could be broken. Are you in pain?”

“I’ll be okay. Where’s Thomas?”

“Who is Thomas?”

“He’s my boyfriend. He takes care of me.”

“Did Thomas do this to you? Beat you?”

“Oh no. We were just drinking, me and Thomas and Carlos. I tripped on the rocks. I want to go now.”

“Well, we’d like to get some X-rays and do a better examination. We have a social worker that could talk to you. She could help you find a place to stay tonight. If you want to make a police report we can help you.”

“No, I want to go. I’ll be all right. But I’d like that sandwich.”

Orlando looked at me with exasperation. He had spent 20 minutes trying to convince the patient to allow us to X-ray her face. He had also participated with me in our medical school’s recent interprofessional education (IPE) exercise a few days earlier that had focused on intimate partner violence. The exercise involved students from medicine, nursing, law, pharmacy, physical therapy, and the physician assistants program. In the exercise, we presented several cases of intimate partner violence and had panels of police, lawyers, psychiatrists, emergency physicians, nurses, and patient advocates describe the epidemiology, presentation, legal requirements, and community resources. At the end they emphasized the importance of recognition and intervention. We had chosen intimate partner violence for the IPE exercise because that problem has a broad reach across the health professions. We wanted the students to be able to interact with each other and learn about each other’s training and roles as well as understand how to approach patients who had experienced intimate partner violence.

Until our IPE exercise, our efforts to bring students from different professional schools together had floundered due to logistical and scheduling problems. The intimate partner IPE exercise appeared to be a first step in the right direction. But now, recognizing my resident’s frustration at encountering a patient with probable intimate partner violence who refused any care, I found myself wondering whether our session had actually addressed the problem of intimate partner violence as it occurs in

the real world, with all of its complex social and psychological forces. I wondered whether our IPE efforts would prepare our students for the reality of the clinical practice environment and the relationships between physicians, social workers, and nurses. Such efforts are needed because current models of health care delivery reform emphasize the importance of teams of professionals to provide better care, particularly for patients with complex social and psychological problems like those of our patient. But with that patient, we seemed to have failed. If our approach was not adequate, could the medical literature help us learn how to provide better IPE that would prepare students for more successful interprofessional collaborative practice?

Unfortunately, recent reports have not been encouraging. The Institute of Medicine (IOM) in a 2015 report<sup>1</sup> noted the misalignment of educational reform and clinical care reform priorities as a major impediment in demonstrating the value of IPE and concluded that

without a purposeful and more comprehensive system of engagement between the education and health care delivery systems, evaluating the impact of IPE interventions on health and systems outcomes will be difficult.

In their report they proposed an interprofessional learning continuum model that recognizes the importance of professional and institutional culture, workforce policy, and financing policy.

In this issue of *Academic Medicine*, Lutfiyya et al<sup>2</sup> also assess the current state of interprofessional education and collaborative practice (IPECP) and conclude that there is limited evidence that IPECP has contributed to better health, better health care, and lower health care costs for the population. For IPECP to reach its potential, they suggest that trainees develop additional knowledge and expertise in population health, informatics, evidence-based and patient-centered care, quality improvement, and

cost-effective health care practice. They also call for increased research to provide evidence of the effectiveness of IPE in fostering collaborative practice and also to better define team care models that lead to improvements in individual and population health. Some of the articles in this issue offer examples of research into IPECP that attempt to meet the challenge offered by Lutfiyya et al.

For example, Van Schaik et al<sup>3</sup> report students' perceptions of peer-to-peer interprofessional feedback. The students were from seven professions (medicine, nursing, pharmacy, dentistry, social work, physical therapy, and dietetics) who participated in an IPE standardized patient exercise. The students found that the feedback about teamwork and interviewing skills was somewhat challenging to give but useful to receive, and that receptiveness toward receiving feedback was not dependent on whether the source of the feedback was a medical, nursing, or other health professions student.

Havyer et al<sup>4</sup> conducted a systematic review to identify tools for evaluating interprofessional collaboration; such collaboration was recently suggested by Englander et al<sup>5</sup> as an important additional competency domain for health professionals. Havyer et al specified four different tools for the best measurement of important team attributes. These attributes were team climate and mutual respect, roles of team members, responsive communication among members of interprofessional teams, and team-based delivery of effective patient-centered care. Use of the suggested tools should help improve research in IPECP as advocated by both the IOM and Lutfiyya et al.

Also in this issue are specific examples of integrating IPE into collaborative practice. Weppner et al<sup>6</sup> describe an interprofessional care team conference for high-risk patients. Physician and nurse practitioner trainees presented cases selected by a nurse case manager, and professional team members from behavioral health, social work, pharmacy, medicine, and nursing worked together to develop a care plan for the patient. They concluded that the interprofessional patient care conference had the potential to improve IPE, collaboration, and patient care.

Tobin-Tyler and Teitelbaum<sup>7</sup> describe medical-legal partnerships that foster

collaboration with physicians and nurses to address health problems exacerbated by legal problems. For example, consider a man suffering from diabetes and peripheral vascular disease who is evicted from his residence and becomes homeless. His medical problems then become much more difficult for him to manage. He may develop complications, such as foot ulcers and infections, that could ultimately lead to sepsis. The medical-legal partnership attempts to utilize legal supports to find solutions that will prevent the worsening of medical conditions associated with legal actions. Medical-legal partnerships typically embed legal services in medical facilities and address issues related to income, insurance, housing, education, employment, legal status, and personal safety.

Finally, Iams et al<sup>8</sup> demonstrate a multidisciplinary quality improvement project involving education about reduction of unnecessary daily lab tests followed by weekly feedback to housestaff and faculty to encourage further reduction efforts. While this project was not strictly an interprofessional one—physician trainees from various specialties were the main participants—it exemplifies how appropriate education can help trainees from multiple programs work collaboratively to develop care delivery improvements that can reduce cost and improve quality of care. This was a project led by trainees rather than institutional leaders and provides a model that could be adopted as an interprofessional project.

While the above articles demonstrate a continuing interest in IPECP to support health care delivery reform, some of them also show that there are still impediments for widespread adoption. If our students experience IPE as part of their learning curriculum but do not encounter collaborative interprofessional teams when they practice, to reinforce what they learned, the education will soon be forgotten. In its report, the IOM identified professional and institutional culture, workforce policy, and financing policy that can facilitate or inhibit the growth of IPE as key elements for adoption of IPECP. From that list I believe that the financing policy may be the most critical element, since overall financing policy related to health will likely encourage reductions in spending

in health care. Should this occur, and should physician workforce shortages develop, there will be added pressure to create new interprofessional care models. The evolution of such models could take many forms, not all of which would lead to high-quality care. However, the examples of collaborative practice described in this issue can be models for future IPECP. They each demonstrate the importance of leadership and institutional culture change, but, interestingly, the leadership does not always have to come from the top of the institutional hierarchy. The promise of these examples, and the potential for bottom-up change, make it incumbent upon us all to examine opportunities for IPECP, even in some of our smaller, more peripheral care units, so that we can begin to get experience with new models of care and ultimately help them spread within our institutions.

As for the patient I described earlier in this essay, she stayed in the emergency department waiting for her sandwich and allowed X-rays to be taken, which were negative. In the process the resident and nurse located a social worker who was able to discuss possible alternatives to the woman's current living arrangements. The nurse and the patient discussed the abusive relationship that had led to the injuries. Ultimately, the patient went to a shelter that night, and the resident and I felt that the IPE exercise we had attended was partly responsible for the outcome, because the stories that had been shared in the program had encouraged us not to give up in spite of our patient's initial resistance.

I am hopeful the same will be true for all of us as we consider incorporating IPECP. We should not give up on this concept in spite of previous disappointments and continuing impediments. We need IPE and IPECP for their contributions to our future workforce and for the opportunities they will present for new and better models of care delivery. I believe they will be features of a future successful health care delivery system, and evidence like this month's articles should encourage our participation *now*. For if not now, when?

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*Editor's Note: The opinions expressed in this editorial do not necessarily reflect the opinions of the AAMC or its members.*

## References

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